CHAPTER V

BILLING INSTRUCTIONS

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SUBMISISON OF BILLING INVOICES

Rehabilitation facilities must submit the billing invoice monthly or within 30 days from the date of the last service or discharge. Interim billings are acceptable. The first copy of the multi-copy invoice form must be submitted in the preaddressed Medicaid envelope. Retain the additional copies for record keeping. All invoices must be mailed; messenger or hand deliveries will not be accepted.

Note: When submitting invoices for rehabilitation services, use the provider number assigned to the rehabilitation unit.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information contact our fiscal agent, First Health Services Corporation:

Phone: (800)-924-6741
Fax number: (804)-273-6797

First Health's website: http://virginia.fhsc.com
E-mail: edivmap@fhsc.com

Mailing Address:

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

COST REPORTING

All rehabilitation agencies are required to maintain separate cost accounting records and to file a cost report annually using the applicable Medicare cost reporting forms (CMS-2552 series) and the Medicaid forms.

- Rehabilitation hospitals

  Medicare CMS–2552-96
  Medicaid DRG-796

- Outpatient Rehab Agency and CORF

  Medicare CMS-2088
  Medicaid CREIMB

DMAS publishes in Appendix B the Rehabilitation Agency Administrator/Owner Compensation Limitations annually which are part of Medicaid's reasonable cost provisions.

Clifton Gunderson P.L.L.C conducts the desk review and settlement of Medicaid cost reports. Clifton Gunderson follows the same policies and procedures that have applied to DMAS' performance of these activities. Send cost reports directly to:

Clifton Gunderson P.L.L.C.
4144-B Innslake Drive
Glen Allen, VA 23060-3387
804-270-2200 (telephone)
804-270-2311 (facsimile)

If a payment to the Medicaid Program is due with the cost report, the payment/check, but not the cost report, must be sent directly to DMAS at the following address:

Department of Medical Assistance Services
Cashiering Unit
Division of Fiscal and Procurement
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Virginia regulations require cost reports to be filed three months after the provider's fiscal year end but do not have explicit enforcement or extension provisions. Therefore, DMAS follows Medicare principles with respect to these issues. Medicare requires cost reports to be filed five months after the provider's fiscal year. If a cost report is not submitted to Medicaid at the end of the five-month period, there is no grace period, and the provider's rate will be reduced to zero immediately.

INQUIRIES CONCERNING BILLING PROCEDURES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Telephone Numbers:

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

Enrollee verification and claim status may be obtained by telephoning:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Enrollee verification and claim status may also be obtained by using the Web-based Automated Response System. See Chapter I for more information.

REPLENISHMENT OF BILLING MATERIALS

CMS-1500 (12-90) Health Insurance Claim Form is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from forms printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 51250-7954

The CMS-1500 (12-90) claim form will not be provided by DMAS.

As a general rule, DMAS will no longer provide a supply of agency forms, which can be downloaded from the DMAS web site (www.dmas.state.va.us). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "provider" to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1-(804)-780-0076.

Requests for information or questions concerning the ordering of forms, call: 1-(804)-780-0076.

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment

checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835. In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health Services Corporation, at (800)-924-6741.

MEDICAID REHABILITATION FACILITY BILLING INVOICES

The use of the appropriate billing invoice is necessary for payment to be made. The accepted billing forms are:

- UB-92 CMS-1450 Universal Claim Form
- Title XVIII (Medicare) Deductible and Coinsurance Invoice - DMAS-30, revised 6/03
- Title XVIII (Medicare) Deductible and Coinsurance Invoice - Adjustment/Void Invoice – DMAS-31, revised 6/96

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which are not submitted within12 months from the date of the service. If billing electronically and timely filing must be waived, submit the claim on paper with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized

to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished timely, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. When the provider did not have knowledge of the Medicaid eligibility of the person prior to rendering the care or service, he or she has 12 months from the date he or she is notified of the Medicaid eligibility in which to file the claim. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the letter from the local department of social services indicating the delayed claim information must be attached to the claim. Request individual consideration for the invoice by entering an explanation in Locator 84 of the UB-92 invoice.

- **Rejected or Denied Claims** - Rejected or denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the invoice as usual, explaining the reason for the late submission in the Remarks section of the invoice.

  - **Attach** written documentation to verify the explanation. This documentation may be denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period.

  - Request individual consideration for the invoice by entering an explanation in Locator 84 of the UB-92 invoice.

  - Submit the claim in the usual manner using the preprinted envelopes supplied by Medicaid or by mailing the claim to:

Department of Medical Assistance Services
Hospital
P. O. Box 27443
Richmond, Virginia 23261-7443

Submit the original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. Messenger or hand deliveries will not be accepted.

- **Exceptions** - The state Medicaid agency is required to adjudicate all claims within 12 months of receipt except in the following circumstances:

  - The claim is a retroactive adjustment paid to a provider who is reimbursed under a retrospective payment system.

  - The claim is related to a Medicare claim, which has been filed in a timely manner, and the Medicaid claim is filed within six months of the disposition of the Medicare claim.

  - This provision applies when Medicaid has suspended payment to the provider during an investigation and the investigation exonerates the provider.

  - The payment is in accordance with a court order to carry out hearing decisions or agency corrective actions taken to resolve a dispute or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those affected by it.

  The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of the specified criteria.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.

- For services requiring preauthorization, all preauthorization criteria must be met in order for the claim to be paid. For those services occurring in a retroactive eligibility period, after-the-fact authorizations will be performed by DMAS.

- **Other Primary Insurance** – The provider should bill other insurance as primary. However, all claims for services must be billed to Medicaid within 12 months from the date of the service. If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of service, no reimbursement can be made by Medicaid as the time for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after December 31, 2003, and all local service codes will no longer be accepted for claims with dates of service after December 31, 2003. All claims submitted with dates of service after December 31, 2003 will be denied if local codes are used.

DMAS will accept the National Standard Formats (NSF) for electronic claims submitted on or before December 31, 2003. On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) will also be accepted. Beginning with electronic claims submitted on or after January 1, 2004, DMAS will only accept HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted). National Codes that replace Local Codes will be accepted for claims with dates of service on or after June 20, 2003. National Codes become mandatory for claims with dates of service on or after January 1, 2004.

The transactions for hospital claims include:

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) claims
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response
- Unsolicited 277 for reporting information on pended claims

Information on these transactions can be obtained from our fiscal agent's website: http://virginia.fhsc.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

CLAIMCHECK

ClaimCheck is a fully automated auditing system that verifies the clinical accuracy of claims submitted and reimbursed. DMAS uses ClaimCheck as a post-payment review of professional and laboratory claims. As a result of this auditing process, DMAS makes the necessary voids or adjustment of the claim(s).

INSTRUCTIONS FOR COMPLETING THE UB-92 CMS-1450 UNIVERSAL CLAIM FORM

The UB-92 CMS-1450 is a universally-accepted claim form that is required when billing DMAS for covered services rendered by participating inpatient/outpatient rehabilitation facilities. The UB-92 CMS-1450 has a multi-purpose format so that it can be used for submitting six different types of transactions: original inpatient and outpatient claims, as well as adjusted or voided inpatient or outpatient claims. This is accomplished by coding transaction-specific information in certain locators on the UB-92 CMS-1450 form. This form is readily available from printers. The UB-92 CMS-1450 **will not** be provided by DMAS.

<u>The UB-92 CMS-1450: General Information</u>

- All dates used on the UB-92 CMS-1450 should be two digits each for the day, the month, and the year (e.g., 010199 with the exception of Locator 14, Patient Birthdate, which requires four digits for the year.
- Note: Do not use any slashes, dashes, or spaces in dates.
- Where there are A, B, and C lines, complete all the A lines, then all the B lines, and finally the C lines. Do not complete A, B, C, and then another set of A, B, C.
- When coding ICD-9-CM diagnostic and procedure codes, do not include the decimal point. The use of the decimal point may be misinterpreted in claims processing.
- Use envelopes supplied by DMAS to submit claims for processing.
- To adjust a previously paid claim, complete the UB-92 CMS-1450 to reflect the proper conditions, services, and charges.
    - Type of Bill (Locator 4) – The last digit of the bill = 7 for adjustments.
    - Locator 37 - Enter the claim ICN/reference number of the paid claim to be adjusted. The claim ICN/reference number appears on the remittance voucher.
    - Remarks (Locator 84) - Enter an explanation for the adjustment.
- To void a previously paid claim, complete the following data elements on the UB-92 CMS-1450:
    - Type of Bill (Locator 4) – The last digit of the bill type = 8 for voids.

- ICN/DCN (Locator 37) - Enter the claim ICN/reference number of the paid claim to be voided. Enter an explanation in Remarks, Locator 84.
- Payer Indicator (Locator 50) - Enter "Medicaid" here.
- Medicaid Provider Number (Locator 51) - Enter the Medicaid provider number.
- Recipient ID Number (Locator 60) - Enter the recipient's 12-digit Virginia Medicaid number.

NOTE: To adjust or void a previously paid **MEDICARE CROSSOVER CLAIM,** be sure to enter the word **"CROSSOVER"** in **Locator 11.**

UB-92 Invoice Instructions

The following description outlines the process for completing the UB-92 CMS-1450. It includes Medicaid-specific information and should be used to supplement the material included in the *State UB-92 Manual*.

Locator		Instructions
1	**Required**	Enter the provider's name, address, and telephone number.
2	Unlabeled Field	
3	**Required (if applicable)**	**PATIENT CONTROL NUMBER** - Medicaid will accept an account number, which does not exceed 17 alphanumeric characters.
4	**Required**	**TYPE OF BILL** - Enter the code as appropriate. Valid codes for Virginia Medicaid are: 111 Original Inpatient Hospital Invoice 116 Adjustment Inpatient Hospital Invoice 118 Void Inpatient Hospital Invoice 131 Original Outpatient Invoice 136 Adjustment Outpatient Invoice 138 Void Outpatient Invoice 741 Original Outpatient Rehab Agency Invoice 746 Adjustment Outpatient Rehab Agency Invoice 748 Void Outpatient Rehab Agency Invoice
5	Not Required	FED. TAX No.
6	**Required**	**STATEMENT COVERS PERIOD** - Enter the

Locator		Instructions
		beginning and ending service dates reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day. If the total days of service exceeds 31 days, use additional billing invoices. Claims submitted which exceed the 31-day limitation will be denied, "Limit of 31 Days Per Billing Invoice Exceeded." The billing period may overlap calendar months as long as the 31-day billing limitation is not exceeded and does not cross over the provider's fiscal year end for cost settlement. Do not include furlough days.
7	**Required**	**COV D. (Covered Days)** - Enter the total number of Medicaid-covered days as applicable. This should be the total number of covered accommodation days/units reported in Locator 46.
8	Not Required	N-CD. (Non-Covered Days) - Enter the days of care not covered for inpatient only. Non-covered days are not included in covered days.
9	Not required	C-ID. (Coinsurance Days)
10	Not required	L-RD. (Lifetime Reserve Days)
11	Unlabeled Field	
12	**Required**	**PATIENT NAME** - Enter the patient's name - last, first, and middle initial.
13	**Required**	**PATIENT ADDRESS** - Enter the patient's address.
14	**Required**	**BIRTHDATE** - Enter the month, date, and full year (MM/DD/YYYY).
15	**Required**	**SEX** - Enter the sex of the patient as recorded on the date of admission, outpatient service, or start of care.
16	**Optional**	**MS (Patient's Marital Status)**
17	**Required**	**DATE (Admission Date)** - Enter the date of admission for inpatient. Enter the date of service for outpatient.
18	**Required**	**HR (Admission Hour)** - Enter the hour during which the patient was admitted for inpatient or outpatient care. (Not required for outpatient rehab agencies).

Locator		Instructions
19	**Required**	**TYPE (Type of Admission)** - For inpatient services only, enter the appropriate code indicating the priority of admission. (Not required for outpatient rehab agencies).
20	**Required**	**SRC (Source of Admission)** - Enter the appropriate code for the source of the admission. (Not required for outpatient rehab agencies).
21	**Required**	**D HR (Discharge Hour)** - Enter the hour the patient was discharged from inpatient care. (Not required for outpatient rehab agencies).
22	**Required**	**STAT (Patient Status)** - Enter the status code as of the ending date in Statement Covers Period (Locator 6). (Not required for outpatient rehab agencies).
23	**Required (if applicable)**	**MEDICAL RECORD NO.** - Enter the number assigned to the patient's medical/health record by the provider for history audits. NOTE: This number should not be substituted for the Patient Control Number (Locator 3 which is assigned by the provider to facilitate retrieval of the individual financial record).
24-30	**Required (if applicable)**	**CONDITION CODES** - Enter the code(s) in numerical sequence (starting with 01) which identify conditions relating to this bill that may affect payer processing. Include the Special Program Indicator codes listed below, if applicable: A1 EPSDT A4 FAMILY PLANNING A7 INDUCED ABORTION DANGER TO LIFE A8 INDUCED ABORTION VICTIM RAPE/INCEST
31	Unlabeled Field	
32-35	**a-b Required (if applicable)**	**OCCURENCE CODES AND DATES** - Enter the code(s) in numerical sequence (starting with 01) and the associated date to define a significant event relating to this bill that may affect payer processing.
36	**a-b Required (if applicable)**	**OCCURRENCE SPAN CODES AND DATES** - Enter the code(s) and related dates that identify an event related to the payment of this claim.

Locator		Instructions
		If code 71 is used, enter the FROM/THROUGH dates given by the patient for any hospital, skilled nursing facility (SNF), or nursing facility stay that ended within 60 days of this hospital admission.
37	**a-c Required (if applicable)**	**INTERNAL CONTROL NUMBER (ICN) DOCUMENT CONTROL NUMBER (DCN)** - Enter the nine-digit claim reference number of the paid claim to be adjusted or voided. A brief explanation of the reason for the adjustment or void is required in Locator 84 (Remarks). NOTE: A=Primary Payer B=Secondary Payer C=Tertiary Payer Cross Reference to Payer Identification in Locator 50 A, B, C (Payer Identification).
38	**Optional**	**RESPONSIBLE PARTY NAME AND ADDRESS**
39-41	**Required**	**VALUE CODES AND AMOUNTS** - Enter the appropriate code(s) to relate amounts or values to identified data elements necessary to process this claim. One of the following codes **must** be used: 82 No Other Coverage 83 Billed and Paid 85 Billed and Not Paid Other codes may be used if applicable.
42	**Required**	**REV. CD. (Revenue Codes)** - Enter the appropriate revenue code(s) for the service provided as follows: **CODE: Three digits, right justified, no leading zeros.** 110 Room and Board, General Classification 120 Room and Board, General Classification 130 Room and Board, General Classification 150 Room and Board, General Classification 230 Incremental Nursing Care, General Classifica-

Locator	Instructions
	tion
250	Pharmacy, General Classification
251	Pharmacy, Generic Drugs
252	Pharmacy, Non-Generic Drugs
253	Pharmacy, Take Home Drugs
255	Pharmacy, Incident to Radiology
257	Pharmacy, Non-Prescription Drugs
258	Pharmacy, IV Solutions
259	Pharmacy, Other Pharmacy
260	Equipment for and Administration of IV's, General Classification
261	Equipment for and Administration of IVs, Infusion Pump
269	Equipment for and Administration of IVs, Other IV Therapy
270	Medical/Surgical, General Classification
272	Medical/Surgical, Sterile Supply
273	Medical/Surgical, Take Home Supplies
274	Medical/Surgical, Prosthetic Devices
277	Medical/Surgical, Oxygen Take Home
279	Medical/Surgical, Other Supplies/Devices
290	Durable Medical, General Classification
291	Durable Medical, Rental
292	Durable Medical, Purchase New
293	Durable Medical, Purchase Used
299	Durable Medical, Other Equipment
300	Laboratory, General Classification
301	Laboratory, Chemistry
302	Laboratory, Immunology
305	Laboratory, Hematology
306	Laboratory, Bacteriology and Microbiology
307	Laboratory, Urology
309	Laboratory, Other
320	Radiology/Diagnostic, General Classification
321	Radiology/Diagnostic, Angiocardiography
322	Radiology/Diagnostic, Arthrography
323	Radiology/Diagnostic, Arteriography
324	Radiology/Diagnostic, Chest X-Ray
329	Radiology/Diagnostic, Other

Locator	Instructions
350	CT Scan, General Classification
351	CT Scan, Head Scan
352	CT Scan, Body Scan
359	CT Scan, Other
360	Operating Room Services, General Classification
361	Operating Room Services, Minor Surgery
369	Operating Room Services, Other
370	Anesthesia, General Classification
371	Anesthesia, Incident to Radiology
379	Anesthesia, Other
400	Other Imaging Services, General Classification
401	Other Imaging Services, Mammography
402	Other Imaging Services, Ultrasound
409	Other Imaging Services
410	Respiratory Services, General Classification
412	Respiratory Services, Inhalation Services
413	Respiratory Services, Hyperbaric Oxygen Therapy
419	Respiratory Services, Other
420*	Physical Therapy, General Classification
421	Physical Therapy, Visit Charge
422*	Physical Therapy, Hourly Charge
423	Physical Therapy, Group Rate
424	Physical Therapy, Evaluation or Re-Evaluation
429*	Physical Therapy, Other
430*	Occupational Therapy, General Classification
431	Occupational Therapy, Visit Charge
432*	Occupational Therapy, Hourly Charge
433	Occupational Therapy, Group Rate
434	Occupational Therapy, Evaluation or Re-Evaluation
439*	Occupational Therapy, Other
440*	Speech-Language Pathology, General Classifi-cation
441	Speech-Language Pathology, Visit Charge
442*	Speech-Language Pathology, Hourly Charge
443	Speech-Language Pathology, Group Rate

Locator	Instructions
444	Speech-Language Pathology, Evaluation or Re-evaluation
449*	Speech-Language Pathology, Other
460	Pulmonary Function, General Classification
469	Pulmonary Function, Other
471	Audiology, Diagnostic
472	Audiology, Treatment
479	Audiology, Other
542	Ambulance, Medical Transport
544	Ambulance, Oxygen
610	Magnetic Resonance Imaging, General Classification
611	Magnetic Resonance Imaging, Brain (including brain stem)
612	Magnetic Resonance Imaging, Spinal Cord including spine)
619	Magnetic Resonance Imaging, Other
621	Medical/Surgical Supplies, Incident to Radiology
700	Cast Room, General Classification
730	EKG/ECG, General Classification
731	EKG/ECG, Holter Monitor
732	EKG/ECG, Telemetry
739	EKG/ECG, Other
740	EEG, General Classification
749	EEG, Other
760	Treatment or Observation Room, General Classification
769	Treatment or Observation Room, Other Treatment
790	Lithotripsy, General Classification
799	Lithotripsy, Other
911	Psychiatric/Psychological Services, Rehabilitation
922	Other Diagnostic Services, Electromyelogram

Locator		Instructions
		941 Other Therapeutic Services, Recreational Therapy 943 Other Therapeutic Services, Cardiac Rehabilitation 946 Other Therapeutic Services, Air Fluid Support Beds 949** Other Therapeutic Services, Cognitive Therapy Only 997 Patient Convenience Items, Admission Kits * These therapy revenue codes do not apply to outpatient rehab providers. ** This code only applies to rehab hospitals and CORFs. 001 Total
43	**Required**	**DESCRIPTION** - Enter the National Uniform Billing Committee (NUBC) description and abbreviation (refer to the State UB-92 billing manual).
44	**Required (if applicable)**	**REVENUE CODES/RATES** Inpatient: Enter the accommodation rate. Outpatient: Enter the applicable Revenue code as shown below. Below is a listing of the old local codes that are replaced with the new national codes as required by HIPAA. Local codes will be accepted for claims with dates of service through December 31, 2003. National codes are optional for claims with dates of service before December 31, 2003 but are mandatory for claims with dates of service on or after January 1, 2004.

Old Code[1]	New Code	Service
Z9471	421	Physical Therapy Visit
Z9473	423	Physical Therapy Group Session
Z9474	424	Physical Therapy, Evaluation/Re-

[1] Providers may begin using the national billing codes for dates of service on or after July 1, 2003. For dates of service after December 31, 2003, national billing codes must be used. Local/national code crosswalk is available on DMAS website.

Locator		Instructions
		evaluation
Z9481	431	Occupational Thearpy Visit
Z9483	433	Occupational Group Session
Z9484	434	Occupational Therapy, Evaluation/Re-evaluation
Z9491	441	Speech-Language Pathology Visit
Z9493	443	Speech-Language Pathology Group Session
Z9494	444	Speech-Language Pathology, Evaluation/Reevaulation

45 **Required (if applicable)** — **SERV. DATE** - Enter the date the service was provided.

46 **Required** — **SERV. UNITS**
Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate.
Outpatient: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit).

47 **Required** — **TOTAL CHARGES (by Revenue Codes)** - Enter the total charge(s) pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges must include only covered charges.

48 **Optional** — **NON-COVERED CHARGES -** Reflects non-covered charges for the primary payer pertaining to the related revenue code. Note: Use revenue code "001" for TOTAL non-covered charges. (Enter the grand total for both total charges and non-covered charges on the same line of revenue code "001").

49 Unlabeled Field

50 **A-C. Required** — **PAYER** - Identifies each payer organization from which the provider may expect some payment for the bill.

A Enter the primary payer identification.
B Enter the secondary payer identification, if applicable.
C Enter the tertiary payer if applicable.

Locator		Instructions
		When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C.
51	**A-C Required**	**PROVIDER NO.** - The Medicaid Provider ID #. Enter the number on the appropriate line. A = Primary B = Secondary C = Tertiary
52	A-C Not Required	REL INFO (Release Information - Certification Indicator)
53	A-C Not Required	ASG BEN (Assignment of Benefits - Certification Indicator)
54	A,B,C,P Not Required	PRIOR PAYMENTS (Payers and Patients)
55	A,B,C,P Not Required	EST AMOUNT DUE
56	Unlabeled Field	
57	Unlabeled Field	
58	**A-C Required**	**INSURED'S NAME** – Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the name on the Medicaid ID card. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card. • Enter the insured's name used by the primary payer identified on Line A, Locator 50. • Enter the insured's name used by the secondary payer identified on Line B, Locator 50. • Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.
59	**A-C Required**	**P. REL** - Enter the code indicating the relationship of the insured to the patient. Refer to the *State UB-92*

Locator		Instructions
		Manual for codes. A = Primary B = Secondary C = Tertiary
60	**A-C Required**	**CERT. - SSN - HIC - ID NO.** - For lines A-C, enter the unique ID# assigned by the payer organization shown on Lines A-C, Locator 58. NOTE: The Medicaid recipient ID# is 12 digits.
61	**A-C Required (if applicable)**	**GROUP NAME** - Enter the name of the group or plan through which the insurance is provided.
62	**A-C Required (if applicable)**	**INSURANCE GROUP NO.** - Enter the ID#, control #, or code assigned by the carrier/administrator to identify the group.
63	**A-C Required (if applicable)**	**TREATMENT AUTHORIZATION CODES** - Enter the number indicating that the treatment is authorized by the payer. This number is required for extensions of PT, OT, and Speech-Language Pathology services on the DMAS-351. Intensive rehab stays (inpatient) must be preauthorized.
64	**A-C Required (if applicable)**	**ESC** (Employment Status Code) – Enter the Code used to define the employment status of the individual identified in Locator 58.
65	**A-C Required (if applicable)**	**EMPLOYER NAME** - Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.
66	**A-C Required (if applicable)**	**EMPLOYER LOCATION** - Enter the specific location of the employer in Locator 65.
67	**Required**	**PRIN. DIAG. CD. (Principal Diagnosis Code)** - Enter the ICD-9-CM diagnosis code that describes the principal diagnosis. **DO NOT USE DECIMALS.**
68-75	**Required (if applicable)**	**Other Diagnosis Code(s)** - Enter the ICD-9-CM diagnosis code(s) for diagnoses other than principal (if any). **DO NOT USE DECIMALS.**
76	**Required**	**ADM. DIAG. CD.** - Enter the ICD-9-CM diagnosis code provided at admission as stated by the physician.

Locator		Instructions
		DO NOT USE DECIMALS.
77	Not required	E-CODE (External Cause of Injury Code)
78	Unlabeled Field	
79	**Required**	**P.C. (Procedure Coding Method Used)** - Enter the code identifying the coding method used in Locators 80 and 81 as follows: 5 – HCPCS 9 - ICD-9-CM Refer to the *State UB-92 Manual* for other codes.
80	**Required (if applicable)**	**PRINCIPAL PROCEDURE CODE AND DATE** - Enter the ICD-9-CM procedure code for the major procedure performed during the billing period**. DO NOT USE DECIMALS.** Any appropriate and available ICD-9-CM procedure codes, that are updated yearly, are to be used for the following therapies: Physical Therapy (Applies to outpatient only) Occupational Therapy (Applies to outpatient only) Speech Therapy (Applies to outpatient only)
81	**A-E Required (if applicable)**	**OTHER PROCEDURE CODES AND DATES** - Enter the code(s) identifying all significant procedures other than the principal procedure (and the dates) on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal. **DO NOT USE DECIMALS.**
82	**Required**	**ATTENDING PHYS. ID.** Inpatient: Enter the seven-digit number assigned by Medicaid for the physician attending the patient. Outpatient: Enter the seven-digit number assigned by Medicaid for the physician who performs the principal procedure. If the recipient is enrolled in MEDALLION, the physician must be the MEDALLION primary care physician (PCP), or there must be a referral from the MEDALLION PCP.
83	**A Required**	**OTHER PHYS. ID.** - Enter the provider number

Locator		Instructions
	(if applicable)	assigned by Medicaid for the Primary Care Physician (PCP) who authorized the inpatient stay or outpatient visit. This is **required** for all MEDALLION patients even though the PCP may be listed in Locator 82. For MEDALLION patients referred to an outpatient clinic, enter the provider ID number assigned by Medicaid for the PCP who authorized the outpatient visit. For Client Medical Management (CMM) patients referred to the emergency room by the PCP, enter the provider ID number and attach the Practitioner Referral Form (DMAS-70). Non-emergency Emergency Room visits will be paid at a reduced rate. Enter the PCP provider number for all inpatient stays. THE PCP # MUST BE IN LOCATOR 83-Aa.
84	**Required (if applicable)**	**REMARKS** - Enter a brief description of the reason for the submission of the adjustment or void (refer to Locator 37). Also, if there is a delay in filing, indicate the reason for the delay here and/or include an attachment. Also, provide other information necessary to adjudicate the claim.
85	**Required**	**PROVIDER REPRESENTATIVE** - Enter the authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of the bill. (Required for paper claims only).
86	**Required**	**DATE** - Enter the date on which the bill is submitted to Medicaid. (Required for paper claims only)

Forward the first payer copy with any attachments for consideration of payment, using the envelope supplied by Virginia Medicaid, or address it to:

Department of Medical Assistance Services
P.O. Box 27443
Richmond, Virginia 23261-7443

Maintain the Institution copy in the provider files for future reference.

INSTRUCTIONS FOR BILLING MEDICARE COINSURANCE AND DEDUCTIBLE

Virginia Medicaid purchases Medicare Part A and Part B coverage for all Medicaid recipients eligible for Medicare benefits and makes payment to providers for Medicare coinsurance and deductible.

The Medicare Program Part A and Part B Carriers serving Virginia and the Virginia Medicaid Program have developed a system whereby these carriers will send to Virginia Medicaid the Medicare Explanation of Benefits (EOB) for identified Virginia recipients. This information will be used by the Program to pay Medicare coinsurance and deductible amounts as determined by the carrier. Do not bill Virginia Medicaid directly for services rendered to Medicaid recipients who are also covered by Medicare Program Part A and Part B carriers serving Virginia. However, the DMAS-31 adjustment form may be used when needed.

If the Medicare Part A and Part B carrier is one of those serving Virginia and the Virginia Medicaid Program, bill Medicare directly on the appropriate invoice.

Upon receipt of the Medicare EOB, Virginia Medicaid will process payment automatically to participating providers when the recipient's Medicare number and the provider's Medicare vendor/provider number are in the Medicaid files. Those providers billing Medicare under more than one Medicare vendor/provider number must identify these numbers and names to the Medicaid Program to update its files. Medicare vendor/provider number additions or deletions must also be sent to the Program.

This automatic payment procedure includes Medicaid recipients with Railroad Retirement Medicare benefits.

If problems are encountered, the DMAS-30 R 6/30 invoice form should be completed, and a copy of the EOB attached and forwarded to:

Department of Medical Assistance Services
Title XVIII
P. O. Box 27441
Richmond, Virginia 23261-7441

NOTE: Medicaid eligibility is reaffirmed each month for most recipients. Therefore, bills must be for services provided during each calendar month, e.g., 01-01-99 - 01-31-99.

Instructions for Billing Medicare Coinsurance and Deductible for Part A and Outpatient Hospital Services

If payment is not received from Medicaid within 60 days of the Medicare payment, the provider should complete and submit the UB92 CMS-1450 claim form.

The following description outlines the process for completing the UB-92 CMS-1450 for **Medicare Part A** and **Outpatient Hospital Services**. It includes Medicaid-specific information and should be used to supplement the material included in the *State UB-92 Manual*.

Locator		Instructions
1	**Required**	**Enter the provider's name, address, and telephone number.**
2	Unlabeled Field	
3	**Required** (if applicable)	**PATIENT CONTROL NUMBER** - Medicaid will accept an account number, which does not exceed 17 alphanumeric characters.
4	**Required**	**TYPE OF BILL** - Enter the code as appropriate. Refer to the UB-92 billing instructions in your Medicaid Provider Manual. * The proper use of these codes (see the *State UB-92 Manual*) will enable DMAS to reassemble cycle-billed claims to form DRG cases for purposes of DRG payment calculations.
5	Not Required	**FED. TAX No.**
6	**Required**	**STATEMENT COVERS PERIOD** - Enter the beginning and ending service dates (in MM/DD/YY-MM/DD/YY format) reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day. Refer to the UB-92 billing instructions in your Medicaid Provider Manual.
7	**Required**	**COV D. (Covered Days)** - Enter the total number of Medicaid-covered days as applicable. This should be the total number of covered accommodation days/units reported in Locator 46.

Locator		Instructions
8	**Required**	**N-CD. (Non-Covered Days)** - Enter the days of care not covered for inpatient only. Non-covered days are not included in covered days. (Not required for outpatient rehabilitation agencies).
9	Not required	C-ID. (Coinsurance Days)
10	Not required	L-RD. (Lifetime Reserve Days)
11	**Required**	**Enter the word "CROSSOVER"**
12	**Required**	**PATIENT NAME** - Enter the patient's name - last, first, and middle initial.
13	**Required**	**PATIENT ADDRESS** - Enter the patient's address.
14	**Required**	**BIRTHDATE** - Enter the month, date, and full year (MMDDCCYY).
15	**Required**	**SEX** - Enter the sex of the patient as recorded on the date of admission, outpatient service, or start of care.
16	**Optional**	MS (Patient's Marital Status)
17	**Required**	**DATE (Admission Date)** - Enter the date of admission for inpatient care. This date must be the same date for all interim claims related to the same admission. Enter the date of service for outpatient care.
18	**Required**	**HR (Admission Hour)** - Enter the hour during which the patient was admitted for inpatient or outpatient care.
19	**Required**	**TYPE (Type of Admission)** - For inpatient services only, enter the appropriate code indicating the priority of admission. A code "1" (emergency) indicates that a copay does not apply.
20	**Required**	**SRC (Source of Admission)** - Enter the appropriate code for the source of the admission. Code "7" (Emergency Room) indicates copay does not apply.
21	**Required**	**D HR (Discharge Hour)** - Enter the hour the patient was discharged from inpatient care.
22	**Required**	**STAT (Patient Status)** - Enter the status code as of the

Locator		Instructions
		ending date in Statement Covers Period (Locator 6). Correct reporting of the patient status code will facilitate quick and accurate determination of DRG reimbursement. In particular, accurate reporting of the values 01, 02, 05, and 30 will be very important in a DRG methodology.
23	**Required (if applicable)**	**MEDICAL RECORD NO.** - Enter the number assigned to the patient's medical/health record by the provider for history audits. NOTE: This number should not be substituted for the Patient Control Number (Loc. 3 which is assigned by the provider to facilitate retrieval of the individual financial record).
24-30	**Required (if applicable)**	**CONDITION CODES** - Enter the code(s) in numerical sequence (starting with 01) which identify conditions relating to this bill that may affect payer processing. Include the Special Program Indicator codes listed below, if applicable: A1 EPSDT A4 FAMILY PLANNING A7 INDUCED ABORTION DANGER TO LIFE A8 INDUCED ABORTION VICTIM RAPE/INCEST
31	Unlabeled Field	
32-35	**a-b Required (if applicable)**	**OCCURRENCE CODES AND DATES** - Enter the code(s) in numerical sequence (starting with 01) and the associated date to define a significant event relating to this bill that may affect payer processing. This is important when billing for days that were exhausted by Medicare.
36	**a-b Required (if applicable)**	**OCCURRENCE SPAN CODES AND DATES** - Enter the code(s) and related dates that identify an event related to the payment of this claim. If code 71 is used, enter the FROM/THROUGH dates given by the patient for any hospital, skilled nursing facility (SNF), or nursing facility stay that ended within 60 days of this hospital admission.
37	**a-c Required (if applicable)**	**INTERNAL CONTROL NUMBER (ICN) DOCUMENT CONTROL NUMBER (DCN)** - Enter the claim ICN/reference number of the paid claim to be

Locator		Instructions
		adjusted or voided. A brief explanation of the reason for the adjustment or void is required in Locator 84 (Remarks). Be sure to use the appropriate type of bill (Locator 4) in combination with the reference number from the incorrect claim. NOTE: A=Primary Payer B=Secondary Payer C=Tertiary Payer Cross-Reference to Payer Identification in Locator 50 A, B, C (Payer Identification).
38	**Optional**	**RESPONSIBLE PARTY NAME AND ADDRESS**
39-41	**Required**	**VALUE CODES AND AMOUNTS** - Enter the appropriate codes to relate amounts or values to identified data elements necessary to process this claim. Line a **83 = Billed and Paid (enter amount paid by Medicare or other insurance).** Line b **A1** = Deductible Payer A. **Enter Medicare Deductible Amount on the EOMB.** Line c **A2** = Co-Insurance Payer A. **Enter Medicare Co-Insurance amount on the EOMB.** **Note: Complete all information in Locators 39a through 41a first (payments by Medicare or other insurance) before entering information in 39b through 41b locators etc.**
42	**Required**	**REV. CD. (Revenue Codes)** - Enter the appropriate revenue code(s) for the service provided as follows: **CODE: Four digits, leading zero, left justified, if applicable.** See the Revenue Codes list under "Exhibits" in your provider manual for approved DMAS codes.
43	**Required**	**DESCRIPTION** - Enter the National Uniform Billing Committee (NUBC) description and abbreviation (refer to the State UB-92 billing manual).

Locator		Instructions
44	**Required (if applicable)**	**HCPCS/RATES** Inpatient: Enter the accommodation rate. Outpatient: Enter the applicable HCPCS code. For Ambulatory Surgical Centers, enter the CPT or HCPCS code on the same line that the revenue code 0490 is entered.
45	**Required (if applicable)**	**SERV. DATE** - Enter the date the service was provided.
46	**Required**	**SERV. UNITS** Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate. Outpatient: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit).
47	**Required**	**TOTAL CHARGES (by Revenue Codes)** - Enter the total charge(s) pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges must include only covered charges. Note: Use code "0001" for TOTAL.
48	**Optional**	**NON-COVERED CHARGES -** Reflects non-covered charges for the primary payer pertaining to the related revenue code. Note: Use revenue code "0001" for TOTAL non-covered charges. (Enter the grand total for both total charges and non-covered charges on the same line of revenue code "0001.")
49	Unlabeled Field	
50	**A-C. Required**	**PAYER** - Identifies each payer organization from which the provider may expect some payment for the bill. A Enter the primary payer identification. B Enter the secondary payer identification, if applicable. C Enter the tertiary payer if applicable. **NOTE**: If **Medicare** is the primary or secondary payer, enter **Medicare** on line A or B. If **Medicaid** is the secondary or tertiary payer, enter **Medicaid** on Lines B

Locator		Instructions
		or C.
51	**A-C Required**	**PROVIDER NO.** - The **Medicare** and **Medicaid** Provider ID #. Enter the number on the appropriate line. A = Primary B = Secondary C = Tertiary
52	A-C Not Required	REL INFO (Release Information - Certification Indicator)
53	A-C Not Required	ASG BEN (Assignment of Benefits - Certification Indicator)
54	**A,B,C,P Required (if applicable)**	**PRIOR PAYMENTS** (Payers and Patients) Long-Term Hospitals - Enter the patient pay amount on "P" line as shown on the DMAS-122 Form furnished by the Local Department of Social Services Office. Note: A=Primary B=Secondary C=Tertiary P= Due from Patient **DO NOT ENTER THE MEDICAID COPAY AMOUNT**
55	A, B, C, P Not Required	EST AMOUNT DUE
56	Unlabeled Field	
57	Unlabeled Field	
58	**A-C Required**	**INSURED'S NAME** - Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the enrollee name when eligibility is verified. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card. • Enter the insured's name used by the primary payer

Locator		Instructions
		identified on Line A, Locator 50. • Enter the insured's name used by the secondary payer identified on Line B, Locator 50. • Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.
59	**A-C Required**	**P. REL** - Enter the code indicating the relationship of the insured to the patient. Refer to the *State UB-92 Manual* for codes. A = Primary B = Secondary C = Tertiary
60	**A-C Required**	**CERT. - SSN - HIC - ID NO.** - For lines A-C, enter the unique ID# assigned by the payer organization shown on Lines A-C, Locator 58. NOTE: The Medicaid enrollee ID # is 12 digits.
61	**A-C Required (if applicable)**	**GROUP NAME** - Enter the name of the group or plan through which the insurance is provided.
62	**A-C Required (if applicable)**	**INSURANCE GROUP NO.** - Enter the ID#, control #, or code assigned by the carrier/administrator to identify the group.
63	Not Required	TREATMENT AUTHORIZATION CODES
64	**A-C Required (if applicable)**	**ESC (Employment Status Code)** - Enter the code used to define the employment status of the individual identified in Locator 58.
65	**A-C Required (if applicable)**	**EMPLOYER NAME** - Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.
66	**A-C Required (if applicable)**	**EMPLOYER LOCATION** - Enter the specific location of the employer in Locator 65.
67	**Required**	**PRIN. DIAG. CD. (Principal Diagnosis Code)** - Enter the ICD-9-CM diagnosis code that describes the principal diagnosis. **DO NOT USE DECIMALS.**
68-	**Required**	**Other Diagnosis Code(s)** - Enter the ICD-9-CM

Locator		Instructions
75	**(if applicable)**	diagnosis code(s) for diagnoses other than principal (if any). **DO NOT USE DECIMALS.**
76	**Required**	**ADM. DIAG. CD.** - Enter the ICD-9-CM diagnosis code provided at admission as stated by the physician. **DO NOT USE DECIMALS.**
77	**Required**	**E-CODE** (External Cause of Injury Code)
78	Unlabeled Field	
79	**Required**	**P.C. (Procedure Coding Method Used)** - Enter the code identifying the coding method used in Locators 80 and 81 as follows: 5 – HCPCS 9 - ICD-9-CM Refer to the *State UB-92 Manual* for other codes.
80	**Required (if applicable)**	**PRINCIPAL PROCEDURE CODE AND DATE** - Enter the ICD-9-CM procedure code for the major procedure performed during the billing period**. DO NOT USE DECIMALS.** For outpatient claims, a procedure code must appear in this locator when revenue codes 360-369, 420-429, 430-439, and 440-449 (if covered by Medicaid) are used in Locator 42 or the claim will be denied. For inpatient claims, a procedure code or one of the diagnosis codes of V64.1 through V64.3 must appear in this locator (or in Locator 67) when revenue codes 360-369 are used in locator 42 or the claim will be denied. Procedure code 8905 will be used by Virginia Medicaid if the locator is left blank. Procedures that are done in the Emergency Room (ER) one day prior to the recipient being admitted for an inpatient hospitalization **from** the ER may be included on the inpatient claim.
81	**A-E Required (if applicable)**	**OTHER PROCEDURE CODES AND DATES** - Enter the ICD-9 CM code(s) identifying all significant procedures other than the principal procedure (and the dates) on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal. **DO NOT USE DECIMALS.**

Locator		Instructions
82	**Required**	**ATTENDING PHYS. ID.** Inpatient: Enter the number assigned by Medicare or Medicaid for the physician attending the patient. Outpatient: Enter the number assigned by Medicare or Medicaid for the physician who performs the principal procedure.
83	Not Required	OTHER PHYS. ID.
84	**Required (if applicable)**	**REMARKS** - Enter a brief description of the reason for the submission of the adjustment or void (refer to Locator 37).
85	**Required**	**PROVIDER REPRESENTATIVE** - Enter the authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of the bill. (Required for paper claims only).
86	**Required**	**DATE** - Enter the date on which the bill is submitted to Medicaid. (Required for paper claims only).

The information may be typed or legibly handwritten. Mail the completed claims and attached EOMBs to:

Department of Medical Assistance Services
Title XVIII
P.O. Box 27441
Richmond, Virginia 23261-7441

Maintain the Institution copy in the provider files for future reference.

UB-92 (CMS-1450) Adjustment and Void Invoices

- To adjust a previously paid claim, complete the UB-92 CMS-1450 to reflect the proper conditions, services, and charges.
  - Type of Bill (Locator 4) – The last digit of the bill type = 7 for adjustments
  - Locator 37 - Enter the claim ICN/reference number of the paid claim to be adjusted. The claim ICN/reference number appears on the remittance voucher.
  - Remarks (Locator 84) - Enter an explanation for the adjustment.

- To void a previously paid claim, complete the following data elements on the UB-92 CMS-1450:
  - Type of Bill (Locator 4) – The last digit of the bill type = 8 for voids.
  - ICN/DCN (Locator 37) - Enter the claim ICN/reference number of the paid claim to be voided. Enter an explanation in Remarks, Locator 84.
  - Payer Indicator (Locator 50) - Enter "Medicaid" here.
  - Medicaid Provider Number (Locator 51) - Enter the Medicaid provider number.
  - Recipient ID Number (Locator 60) - Enter the recipient's 12-digit Virginia Medicaid number.

NOTE: To adjust or void a previously paid **MEDICARE CROSSOVER CLAIM,** be sure to enter the word **"CROSSOVER"** in **Locator 11.**

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice FOR PART B ONLY, DMAS-30 – R 6/03

Purpose: To provide a method of billing Virginia Medicaid for Medicare deductible and coinsurance.

NOTE: This form can be used for four different procedures per Medicaid recipient. A different form must be used for each Medicaid enrollee.

Block 01 **Provider's Medicaid ID Number** – Enter Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 02 **Recipient's Last Name** – Enter the last name of the patient as it appears from the enrollee's eligibility verification.

Block 03 **Recipient's First Name** – Enter the first name of the patient as it appears from the enrollee's eligibility verification.

Block 04 **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Recipient's HIB Number (Medicare)** – Enter the enrollee's Medicare number.

Block 07 **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation).

- **Code 2 – No Other Coverage** – If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
- **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare) – Mark type of coverage B only.**

Block 09 **Diagnosis** – Enter the principal ICD-9-CM diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** – Enter the appropriate national place of service code.

Block 11 **Accident/Emergency Indicator** – Check the appropriate box, which indicates the reason the treatment, was rendered:

- **ACC** – Accident, Possible third-party recovery
- **Emer** – Emergency, Not an accident
- **Other** – If none of the above

Block 12 **Type of Service** – Enter the appropriate national code describing the type

of service.

Block 13 **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. If there was no procedure code billed to Medicare, leave this block blank. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** – Enter the date of admission

Block 16 **Statement Covers Period** – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** – Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** – Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** – Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** – Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Co-insurance** – Enter the amount of the co-insurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 23 **Patient Pay Amount, LTC Only** – Enter the patient pay amount, if applicable.

Block 24 **Remarks** – If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Adjustment Invoice PART B ONLY, DMAS-31 (Revised 6/96)

Adjustment Coinsurance Invoice, DMAS-31 (Revised 6/96)

The adjustment invoice is used to change information on a **paid** claim. This form cannot be used for the follow-up of denied or pended claims.

Void Coinsurance Invoice, DMAS-31 (Revised 6/96)

The void invoice is used to void the original payment. The information on the invoice must be identical to the original invoice.

Purpose To provide a means of making corrections or changes to claims that have been approved for payment. This form cannot be used for the follow-up of denied, or pended claims. (See the "Exhibits" section at the end of this chapter for a sample of this form).

Explanation To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.

Block 1 **Adjustment/Void** - Check the appropriate block.

Block 2 **Provider Identification Number** – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 2A **Reference Number** - Enter the reference number/ICN taken from the Remittance Voucher for the line of payment needing an adjustment. The adjustment cannot be made without this number since it identifies the original invoice.

Block 2B **Reason** - Leave blank.

Block 2C **Input Code** - Leave blank.

Block 3 **Clients' Name** - Enter the last name and the first name of the patient as they appear on the enrollee's eligibility card.

Block 4 **Client's Identification Number** - Enter the 12-digit number taken from the enrollee's eligibility card.

Block 5 **Patient Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance voucher after the claim is processed.

Block 6 **Client HIB Number** (Medicare) - Enter the enrollee's Medicare number.

Block 7 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation).

- **Code 2 - No Other Coverage** –If there is no other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 - Billed and Paid** - When an enrollee has other coverage that makes payment which may only satisfy in part the Medicare deductible and coinsurance, check Block 3 and enter the payment received in Block 19. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
- **Code 5 - Billed and No Coverage** - If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 8 **Type Coverage (Medicare)** - Mark type of coverage "B".

Block 9 **Diagnosis** - Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code can be processed.

Block 9A **Place of Treatment** - Enter the appropriate national place of service code:

Block 10 **Accident Indicator** - Check the appropriate box which indicates the reason the treatment was rendered:

- **Accident** - Possible third-party recovery
- **Emergency** - Not an accident
- **Other** - If none of the above

Block 11 **Type of Service** - Enter the appropriate national code describing the type of service:

Block 11A **Procedure Code** - Enter the 5-digit CPT/HCPCS code, which was billed to Medicare. Each procedure must be billed on a separate line. If there is no procedure code billed to Medicare, leave this blank. Use the appropriate national procedure code modifier if

applicable.

Block 11B **Visits/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" as billed to Medicare. (Block 13)

Block 12 **Date of Admission** –Enter the date of admission (if applicable).

Block 13 **Statement Covers Period** - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru), e.g., 03-01-03 to 03-31-03.

Block 14 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 15 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 16 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOMB).

Block 17 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOMB).

Block 18 **Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOMB).

Block 19 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 20 **Patient Pay Amount, LTC Only** - Leave blank.

Signature Signature of the provider or the agent and the date signed are required.

Mechanics and Disposition The information may be typed or legibly handwritten. Mail the completed claims to:

Department of Medical Assistance Services
Title XVIII
P. O. Box 27441
Richmond, Virginia 23261-7441

Retain a copy for the office files.

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross reference number, and entered into the system, it is placed in one of the following categories:

TURNAROUND DOCUMENT LETTER (TAD)

If lines on an invoice are completed improperly, a computer-generated letter (TAD) is sent to the provider to correct the error. The TAD should be returned to First Health. The claim will be denied if the TAD is not received in the system within 21 days. Only requested information should be returned. Additional information will not be considered and may cause the claim to deny in error.

- Remittance Voucher
    - **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).
    - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

SPECIAL BILLING INSTRUCTIONS - CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

The primary care physician (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter I under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary care physician or on referral from the primary care physician must place the primary care physician's Medicaid provider number in Locator 17a and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70, or for remarks as appropriate.
17a	When a restricted enrollee is treated on referral from the primary physician, enter the primary physician's Medicaid provider number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d.
24I	When a restricted enrollee is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

EDI BILLING (ELECTRONIC CLAIMS)

Follow the instructions for the 837 transaction and the standard for attachments using the Claim Attachment Form (DMAS-3).

EXHIBITS

TABLE OF CONTENTS

APPROVED OMB NO. 0938-0279

	2							3 PATIENT CONTROL NO.	4 TYPE OF BILL
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11	
12 PATIENT NAME		13 PATIENT ADDRESS							
14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.

24	25	26	27	28	29	30	31
CONDITION CODES							

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a											A
b											B
c											C

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT	
a							a
b							b
c							c
d							d

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
								1
								2
								3
								4
								5
								6
								7
								8
								9
								10
								11
								12
								13
								14
								15
								16
								17
								18
								19
								20
								21
								22
								23

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	
							A
							B
							C
57		DUE FROM PATIENT ▶					

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	
					A
					B
					C

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	
				A
				B
				C

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID	
								a
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID	b
								a
							OTHER PHYS. ID	b
								a
								b

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a	X	
b		
c		
d		

UB-92 HCFA-1450 **OCR / Original**

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

01 Provider's Medicaid ID Number	02 Last Name	03 First Name

04 Recipient ID Number	05 Patient's Account Number	06 Recipient's HIB Number (Medicare)

1

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	From MM DD YY	16 Statement Covers Period MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

2

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	From MM DD YY	16 Statement Covers Period MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

3

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	From MM DD YY	16 Statement Covers Period MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

4

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	From MM DD YY	16 Statement Covers Period MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

24 Remarks

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

DMAS - 30 R 6/03

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice FOR PART B ONLY, DMAS-30 – R 6/03

Purpose: To provide a method of billing Virginia Medicaid for Medicare deductible and coinsurance.

NOTE: This form can be used for four different procedures **per** Medicaid recipient. A different form must be used for **each** Medicaid enrollee.

Block 01 **Provider's Medicaid ID Number** – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 02 **Recipient's Last Name** – Enter the last name of the patient as it appears from the enrollee's eligibility verification.

Block 03 **Recipient's First Name** – Enter the first name of the patient as it appears from the enrollee's eligibility verification.

Block 04 **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Recipient's HIB Number (Medicare)** – Enter the enrollee's Medicare number.

Block 07 **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 – No Other Coverage** – If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
- **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare)** – Mark the appropriate type of Medicare coverage.

Block 09 **Diagnosis** – Enter the principal ICD-9-CM diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** – Enter the appropriate national place of service code.

Block 11 **Accident/Emergency Indicator** – Check the appropriate box, which indicates the reason the treatment, was rendered:

- **ACC** – Accident, Possible third-party recovery
- **Emer** – Emergency, Not an accident
- **Other** – If none of the above

Block 12 **Type of Service** – Enter the appropriate national code describing the type of service.

Block 13 **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. If there was no procedure code billed to Medicare, leave this block blank. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** – Enter the date of admission.

Block 16 **Statement Covers Period** – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** – Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** – Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** – Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** – Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Co-insurance** – Enter the amount of the co-insurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 23 **Patient Pay Amount, LTC Only** – Enter the patient pay amount, if applicable.

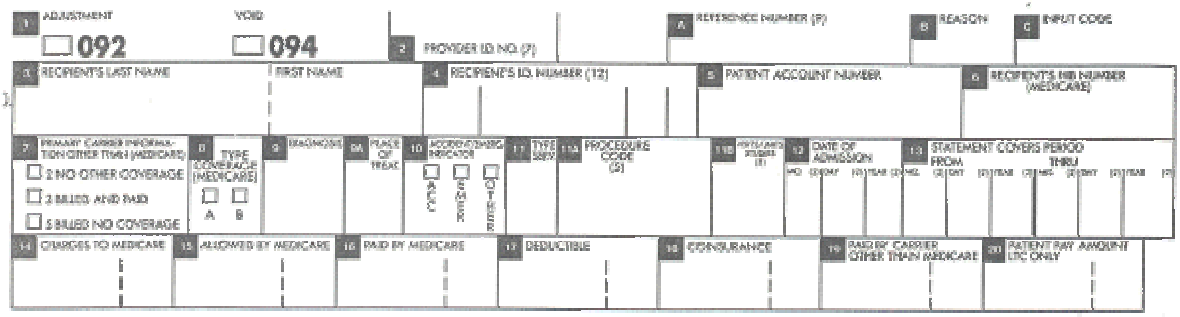
Block 24 **Remarks** – If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES



_____ DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

ORIGINAL COPY

DMAS 31 R 6/86

INSTRUCTIONS FOR THE COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE ADJUSTMENT INVOICE FOR PART B ONLY, DMAS-31 (REVISED 6/96)

Adjustment Coinsurance Invoice, DMAS-31 (Revised 6/96)

The adjustment invoice is used to change information on a **paid** claim. This form cannot be used for the follow-up of denied or pended claims.

Void Coinsurance Invoice, DMAS-31 (Revised 6/96)

The void invoice is used to void the original payment. The information on the invoice must be identical to the original invoice.

Purpose	To provide a means of making corrections or changes to claims that have been approved for payment. This form cannot be used for the follow-up of denied, or pended claims. (See the "Exhibits" section at the end of this chapter for a sample of this form).
Explanation	To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.
Block 1	**Adjustment/Void** - Check the appropriate block.
Block 2	**Provider Identification Number** – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid.
Block 2A	**Reference Number** - Enter the reference number/ICN taken from the Remittance Voucher for the line of payment needing an adjustment. The adjustment cannot be made without this number since it identifies the original invoice.
Block 2B	**Reason** - Leave blank.
Block 2C	**Input Code** - Leave blank.
Block 3	**Clients' Name** - Enter the last name and the first name of the patient as they appear on the enrollee's eligibility card.
Block 4	**Client's Identification Number** - Enter the 12-digit number taken from the enrollee's eligibility card.
Block 5	**Patient Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance voucher after the claim is processed.
Block 6	**Client HIB Number** (Medicare) - Enter the enrollee's Medicare number.

Block 7 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation).

- **Code 2 - No Other Coverage** –If there is no other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.

- **Code 3 - Billed and Paid** - When an enrollee has other coverage that makes payment which may only satisfy in part the Medicare deductible and coinsurance, check Block 3 and enter the payment received in Block 19. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.

- **Code 5 - Billed and No Coverage** - If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 8 **Type Coverage (Medicare)** - Mark type of coverage "B".

Block 9 **Diagnosis** - Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code can be processed.

Block 9A **Place of Treatment** - Enter the appropriate national place of service code:

Block 10 **Accident Indicator** - Check the appropriate box which indicates the reason the treatment was rendered:

- **Accident** - Possible third-party recovery
- **Emergency** - Not an accident
- **Other** - If none of the above

Block 11 **Type of Service** - Enter the appropriate national code describing the type of service:

Block 11A **Procedure Code** - Enter the 5-digit CPT/HCPCS code. which was billed to Medicare. Each procedure must be billed on a separate line. If there is no procedure code billed to Medicare, leave this blank. Use the appropriate national procedure code modifier if applicable.

Block 11B **Visits/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" as billed to Medicare. (Block 13)

Block 12 **Date of Admission** –Enter the date of admission (if applicable).

Block 13 **Statement Covers Period** - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru), e.g., 03-01-03 to 03-31-03.

Block 14 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 15 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 16 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOMB).

Block 17 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOMB).

Block 18 **Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOMB).

Block 19 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 20 **Patient Pay Amount, LTC Only** - Leave blank.

Signature Signature of the provider or the agent and the date signed are required.

Mechanics and Disposition The information may be typed or legibly handwritten. Mail the completed claims to:

Department of Medical Assistance Services
Title XVIII
P. O. Box 27441
Richmond, Virginia 23261-7441

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN):

Patient Account Number (20 positions limit)* **M M D D C C Y Y Sequence Number (5 digits)**
Date of Service

***Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.**

Provider Number:	**Provider Name:**

Enrollee Identification Number:

Enrollee Last Name:	**First:**	**MI:**

☐ **Paper Attached** ☐ **Photo(s) Attached** ☐ **X-Ray(s) Attached**

☐ **Other (specify)**_____

COMMENTS:_____

_____

_____

_____

_____

_____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.state.va.us. Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

DMAS – 3

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 1234567890701200312345).
IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.

2. **Date of Service** – Enter the from date of service the attachment applies to.

3. **Sequence Number** –Enter the provider generated sequence number up to 5 digits only.

4. **Provider Number** – Enter the Medicaid Provider number.

5. **Provider Name** – Enter the name of the Provider.

6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.

7. **Enrollee Last Name -** Enter the last name of the Enrollee.

8. **First** – Enter the first name of the Enrollee.

9. **MI –** Enter the middle initial of the Enrollee.

10. **Type of Attachment –** Check the type of attachment or specify.

11. **Comment –** Enter comments if necessary.

12. **Authorized Signature –** Signature of the Provider or authorized Agent.

13. **Date Signed** – Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number. Mailing addresses are available in the Provider manuals or check the DMAS website at www.dmas.state.va.us.

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRIOR REVIEW AND AUTHORIZATION REQUEST

1 Original ☐ 2 Cancel ☐ 3 Change ☐

Page _____ of _____

SERVICING PROVIDER INFORMATION

Number 4

Name 5

Contact Person 6

Phone 7

Enrollee ID# 8

Enrollee Name:

Last 9

First 10

MI 11

Referring Provider # 12

13 ☐ Other Non-Paper Enclosure 14 ☐ X-Rays Enclosure 15 ☐ Photographs Enclosure

Diagnosis Code 16

PA Number 17 (If cancellation or Change)

PA Service Type 18

1	19 ☐ 20 ☐	HCPCS/CPT Revenue Code 21		22					Units requested 23 Amount Requested 24			
	Desc 25								Line # If Requesting Cancellation Or Change) 26			
	Dates of Service requested (MM/DD/YY) FROM 27								To 28			
2	19 ☐ 20 ☐	HCPCS/CPT Revenue Code 21		22					Units requested 23 Amount Requested 24			
	Desc 25								Line # If Requesting Cancellation Or Change) 26			
	Dates of Service requested (MM/DD/YY) FROM 27								To 28			
3	19 ☐ 20 ☐	HCPCS/CPT Revenue Code 21		22					Units requested 23 Amount Requested 24			
	Desc 25								Line # If Requesting Cancellation Or Change) 26			
	Dates of Service requested (MM/DD/YY) FROM 27								To 28			
4	19 ☐ 20 ☐	HCPCS/CPT Revenue Code 21		22					Units requested 23 Amount Requested 24			
	Desc 25								Line # If Requesting Cancellation Or Change) 26			
	Dates of Service requested (MM/DD/YY) FROM 27								To 28			
5	19 ☐ 20 ☐	HCPCS/CPT Revenue Code 21		22					Units requested 23 Amount Requested 24			
	Desc 25								Line # If Requesting Cancellation Or Change) 26			
	Dates of Service requested (MM/DD/YY) FROM 27								To 28			
6	19 ☐ 20 ☐	HCPCS/CPT Revenue Code 21		22					Units requested 23 Amount Requested 24			
	Desc 25								Line # If Requesting Cancellation Or Change) 26			
	Dates of Service requested (MM/DD/YY) FROM 27								To 28			

FOR ADDITIONAL PROCEEDURES FOR THE SAME PA#, USE AN ADDITIONAL FORM – ENTER BOXES 4,5,12,13,14, AND 1 ON EACH ADDITIONAL FORM

29 Provider Signature _____ 30 Date Signed _____

DMAS -351 R 6/03

Instructions For Completion of the DMAS 351 – Virginia Department of Medical Assistance Services "Prior Review and Authorization Request" Form

The DMAS 351 is to be used when requesting a new prior authorization, to request a change an existing authorization, or to cancel an existing authorization. Note: A cancellation request can only be honored if there has been no claims activity posted against the authorization.

HEADER DATA

1 – 3	Put an "X" in the box next to the type of request being submitted.
4 – 7	Servicing Provider Information: includes provider ID #, name, a contact person's name, and telephone number.
8 – 11	Enrollee (Patient) Information: includes enrollee ID#, last name, first name, middle initial.
12	Referring Provider ID # (if applicable).
13 – 15	Indicate if attaching a non-paper enclosure, x-ray, or photograph for review.
16	Enter the primary diagnosis code for the enrollee.
17	Enter the PA Number (tracking number) if requesting a change or cancellation.
18	Enter the appropriate PA Service Type. (See listing in Provider Manual with these instructions.

LINE ITEM DATA

Each form will accommodate up to 6 lines of requests for authorization of services or equipment. If more than 6 lines are needed, use additional DMAS-351's to request additional services or equipment. Be sure to indicate the number of the pages being submitted (top right), especially if more than one DMAS-351 is required.

19 – 25	Indicate the type of procedure code, the procedure code, up to 4 modifiers (if applicable), the number of units requested, amount requested, and a description of the item/service requested.
26	Enter the line # for which you are requesting a change or cancellation.
27 – 28	Enter the From Date and To Date of Service
29 – 30	Provider's signature and date signed.

<u>ATTACHMENTS</u>

Attach required and supportive medical documentation to the completed DMAS-351 and submit to:

Virginia Medical Assistance Program
P.O. Box 25507
Richmond, VA 23261

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRIOR REVIEW AND AUTHORIZATION REQUEST
SUPPORTING DOCUMENTATION

1 ☐ Return Pend Documentation
2 ☐ Request for Reconsideration
(Check only (1) box)

Pending or Denied PA # (if known)
3 _____

4 Check appropriate box(es)

Line 1 ☐	Line 2 ☐	Line 3 ☐	Line 4 ☐	Line 5 ☐	Line 6 ☐
Line 7 ☐	Line 8 ☐	Line 9 ☐	Line 10 ☐	Line 11 ☐	Line 12 ☐
Line 13 ☐	Line 14 ☐	Line 15 ☐	Line 16 ☐	Line 17 ☐	Line 18 ☐

PROVIDER INFORMATION

Number: 5 _____

Name: 6 _____

Contact Person: 7 _____

Phone: 8 _____

Enrollee ID# : 9 _____

Enrollee Name:

Last: 10 _____

First: 11 _____

MI: 12 ☐

13 ☐ Other Non-Paper Enclosure
14 ☐ X-Rays Enclosed
15 ☐ Photographs Enclosed
16 ☐ Dental Models Enclosed

PA Service Type: 17 _____

18 COMMENTS: _____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE, ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

19 Provider Signature _____ 20 Date Signed _____

Instructions For Completion of the DMAS-361
Virginia Department of Medical Assistance Services
"Prior Review and Authorization Request Supporting Documentation"

The DMAS-361 is to be used when returning requested documentation in response to a pend, to request reconsideration of an adverse prior authorization decision, or if sending in orthodontic models separate from the prior authorization request. This form and applicable attachments should be submitted to:

Virginia Medical Assistance Program
P.O. Box 25507
Richmond, VA 23261

INSTRUCTIONS BY INDICATOR NUMBER:

1. Return Pend Documentation:	Mark with an "X" if returning documentation in response to a pend.
2. Request for Reconsideration:	Mark with an "X" if requesting reconsideration in response to an adverse prior authorization decision.
3. Pending or Denied PA#:	Enter the PA or Tracking Number (if known). If sending in orthodontic models for authorization, leave this field blank.
4. Check appropriate box(es):	Identify which line(s) of the Prior Authorization to refer to.
5. Provider Number:	Enter the provider's Medicaid ID #.
6. Name:	Enter the provider's name.
7. Contact Person:	Enter a Contact's name representing the provider.
8. Phone:	Enter the telephone number at which the Contact can be called.
9. Enrollee ID #:	Enter the enrollee or patient's Medicaid ID #.
10 – 12 Enrollee Name:	Enter the enrollee for patient's last name, first name and middle initial.
13 – 16 Enclosure Type:	Enter an "X" in the appropriate box to indicate enclosure type.
17. PA Service Type:	Enter the appropriate PA Service Type. (See listing in provider manual).
18. Comments:	Enter any comments that provide clarification or further information.
19 – 20 Provider Signature & Date	The provider must sign and date the form.

PA SERVICE TYPES

CATEGORY	DESCRIPTION	PA TYPE #	HIPAA PA #	LOC
Mental Health/SA	Outpatient Psych Services	0050	A8	
	Substance Abuse (FAMIS)	0051	AI	
EPSDT Non-State Plan Services	Private Duty Nursing	0090	74	
	Personal Care	0091	42	
	EPSDT DME	0092	12	
	EPSDT Inpatient Psych	0093	A7	
DME	Home	0100	12	
	Nursing Home	0101	12	
	Tech Waiver	0102	12	
REHAB	Intensive Inpt.	0200	AB	
	CORF	0201	AC	
	Special Vent Contract	0202	Non-EDI Request	
	Special Contract (Out of State)	0203	Non-EDI Request	
	Outpt. Rehab	0204	AC	
Medical Support	Organ Transplants	0300	70	
	Out of State Services	0301	1	
	Surgical/Invasive	0302	2	
	Prosthetics	0303	75	
	Muscular/Skeletal Devices	0304	BS	
	Vision	0305	AL	
	Other	0306	1	
Hospital	Inpatient Med/Surg	0400	48	
	Inpatient Psych	0401	48	
Home Health	Home Health	0500	44	
Community MHMR Services	Community MHMR Services	0600	A4	
ECM	Elderly Case Management	0625	3	
TFC CM	Treatment Foster Care Case Mgmt.	0700	3	
Residential Treatment	CSA	0750	A7	
	Non-CSA	0751	A7	
Dental Services	Children, Under 21 years old	0800	35	
	Orthodontic, Under 21 years old	0801	38	
	Adult, Over 21 years old	0850	35	
CATEGORY	DESCRIPTION	PA TYPE #	HIPAA PA #	LOC

Community Based Care (CBC) Waivers	**Elderly & Disabled Waiver (E&D)**	**0900**	**54**	**9**
	IFDDS (Individual and Family Development Disability Services)	**0902**	**54**	**R**
	AIDS Waiver (Respite Care 720 Hrs. Max.)	**0920**	**54**	**E**
	Mental Retardation Waiver (MR)	**0940**	**54**	**Y**
	CDPAS (Consumer Directed Personal Assistant Services)	**0950**	**54**	**Q**
	Tech Waiver (PDN & Respite Care 360 Hrs. Max.)	**0960**	**54**	**A**